2009 HEALTH SYSTEM REFORM TASK FORCE
COMMUNITY WORKING GROUPS: MEMBERSHIP, ISSUES, FUNCTIONS, AND REPORTS

TASK FORCE: Will meet monthly on interim day to make policy decisions and evaluate the issues assigned by H.B. 188. The task force will request three community working groups to meet and make recommendations to the task force regarding specific issues assigned by the task force.

COMMUNITY WORKING GROUPS: Each group will be a multi-stakeholder group. The community working groups will be given a list of specific tasks and issues and a time line for bringing recommendations back to the task force. The task force may request the community groups to form specific subgroups to address issues assigned to the community working groups. The community working groups should supervise the subgroups and report the community working groups' recommendations to the task force. (The community working groups could function in a similar manner as the toll gate review process at HealthInsight.) We expect each working group to provide specific findings and tangible ideas for our next step and feedback regarding the validity of our current reform efforts. Dates, times and locations of meetings for the community working groups will be published on the Office of Consumer Health Services website.

ISSUE ORIENTED SUBGROUPS: Subgroups will be formed at the request of the task force. Their work and recommendations should be supervised and vetted by their respective community working groups prior to the working groups bringing the recommendations back to the task force.

COMMUNITY GROUPS AND ISSUES

COMMUNITY WORKING GROUP 1: AFFORDABILITY AND ACCESS

1. Health care delivery and payment reform
2. Administrative simplification
3. The UPP, CHIP and Medicaid programs (outreach, enrollment, cost effective utilization strategies, and pharmaceutical assistance programs)

Subgroup 1: **Health care delivery and payment reform**

Membership:
The demonstration project committee and process established through HealthInsight. All health care insurers in the market, including PEHP and Medicaid, should be invited to attend. Employers and health care providers should also be included.

Task:

1. Adopt a process to establish consensus for a broad-based demonstration project among health care stakeholders. (Health Insight recommends use of the Six Sigma process.)
2. Consider how to develop consensus for best practices and quality measures.
3. Establish recommendations for accelerating the acceptance and use of a broad-based demonstration project, which may include:
   - use of best practices;
   - health care payment and delivery reform; and
   - health care quality measures.

Report to Task Force:
Monthly progress reports and report including proposed demonstration project participants by October 2009 task force meeting.

Subgroup 2: Administrative simplification

Membership:
Convened by the Insurance Department as required by H.B. 188. Membership should include at least:

- Regence BCBS, Altius, SelectHealth, Humana, United Healthcare, and Aetna;
- representatives with billing and payment experience from providers such as the University Health Care, MountainStar, IASIS Healthcare, and Intermountain Healthcare
- a physician representative;
- a health care clinic representative;
- a person from the state's Medicaid program with billing and payment system experience;
- a community advocacy representative; and
- a representative of the Utah Health Information Network familiar with the development of national standards for card-swipe technology for insurance cards.

Task:

1. Develop standards, including uniform use of terms, to make explanation of benefits statements more understandable.
2. Create a more efficient coordination of benefits process.
3. Establish a preauthorization process that is more real-time and meaningful.
4. Select a national standard for insurance benefit swipe cards and recommend ways to accelerate its use among insurers and providers.

Report to the task force:
Proposed rules or legislation should be presented to the task force by September 2009.

COMMUNITY WORKING GROUP 2: TRANSPARENCY - QUALITY-INFRASTRUCTURE

1. Accelerate the development and use of the infrastructure necessary to electronically access and exchange clinical health records, quality comparisons of health care providers and insurers, and the cost and pricing of medical procedures.
2. Explore the disclosure or regulation of insurer medical loss ratios (create a definition of medical loss ratio and determine whether ratios should be regulated or disclosed).
3. Wellness and healthy behaviors.

Subgroup 1: Infrastructure

Membership:
Members should have an understanding of the "all-payers database," the development of standards for the electronic exchange of clinical health information, and the roles of UHIN and the Health Data Authority. Members should include users of health data, including physicians, hospitals, clinics, insurers, and patients. Members should also include representatives of the Health Data Committee within the Department of Health and the Utah Health Information Network.

Task:

1. What can be done to accelerate the availability and use of risk-adjusted episodes of care data?
2. What can be done to accelerate the use and exchange of electronic health records?
3. What can be done by the state to make Medicaid and PEHP model third-party payers?

Report to Task Force:
Provide the task force with an initial report on the development of the all-payers database and standards for the electronic exchange of clinical health information. Provide recommendations to the task force by September 2009.

Subgroup 2: Wellness and Healthy Behaviors

Membership:
Insurers in the state, including Regence BCBS, Altius, SelectHealth, Humana, United Healthcare, Molina, and PEHP; representatives of small and large employers; the Department of Health; health care providers; PhRMA (Pharmaceutical Research and Manufacturers of America); and a community advocacy representative.

Task:

1. How much do wellness programs and incentives affect short-term and long-term insurance costs in the small group market, large group market, and the self-insured market?
2. Why don't all insurers use wellness incentives such as reduced premiums, or reduced deductibles, copayments or coinsurance, to the full extent allowed by federal law (20% differential) for enrollees who reach wellness goals and maintain healthy lifestyles?
3. What can be done to more effectively promote healthy behaviors and wellness?
4. How can we improve disease management and compliance with appropriate treatments?

Report to task force: October, 2009

COMMUNITY WORKING GROUP 3: OVERSIGHT AND IMPLEMENTATION - Defined Contribution Market and Portal

1. Monitor and facilitate the progress and development of the portal.
2. Monitor and facilitate the development of the defined contribution market.
3. Monitor and facilitate the development of the risk adjuster mechanism for the defined contribution market, including the 2012 expansion to large employers and greater product choices.
4. Explore the potential participation by PEHP and other association health plans in the defined contribution market in 2012.

Subgroup 1: Risk adjuster and defined contribution market expansion to large employers

Membership:
Large self-insured employers, large employers insured by state regulated health plans or with the assistance of third party administrators, the Office of Consumer Health Services, the Utah Insurance Department, state regulated health insurers, a representative from the Utah Defined Contribution Risk Adjuster Board, and a community advocacy representative.

Task:

1. What would be the most effective methods for rating and for risk allocation among insurance carriers when large employers join the defined contribution market?
2. Does the standard application for the defined contribution market need to be adjusted to efficiently incorporate large groups into the defined contribution market?
3. How would the risk adjuster mechanism need to be structured to provide a greater variety of plan choices in the defined contribution market?
4. What should be the role of the small employer group market once the defined contribution market is operational? Two years down the road? Five years down the road?
5. Is the portal being developed and implemented in accordance with the intent of H.B. 133 and H.B. 188?
    - Can the portal support the incorporation of large groups in the defined contribution market by 2012?
    - Is the information submitted by insurers sufficient for a consumer to make a purchasing decision?
    - What steps should be taken next to make the portal a vehicle for promoting the availability of affordable, portable, and flexible health plans?

Report to task force:

June report on the portal, including a demonstration of functionality. Progress reports to the task force in August and September. Final report to the task force in October.

Subgroup 2: PEHP and other association health plans participation in the defined contribution market.

Membership:

PEHP, insurers participating in the defined contribution market, a business community representative, and a community representative.

Task:

1. How can the state use its role as a major purchaser of health insurance to encourage value-based purchasing of health insurance and health care services?
2. What legal and implementation issues are there if PEHP or other association health plans participate in the defined contribution market?
3. What steps should be taken next?

Report to Task Force:

Progress reports to the task force in August and September. Final report to the task force in October.